MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

00 92

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 81 years
Hospital, institution, or street address where death occurred: 24 Washington St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 Washington St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nanny Bell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

B.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 28 1863

8. AGE: Years	Months	Days	If less than one day
81	8		hrs. min.

9. Birthplace: Annapolis A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Peter Murdock
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Harriet Anderson
15. Birthplace: Annapolis Md.

16. Informant: Ardenia Parker
Address: 24 Washington St Annapolis Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 1/14/45 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West Street

18. Funeral director: Othel F. Hicks
Address: 45 Northwest St Annapolis Md

19. Jan. 10 1945
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8 1945, at 7 P. M. 40

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~.....~~ to ~~.....~~ and that I last saw h~~.....~~ alive on January 8 1945

Immediate cause of death: Congestive Heart Disease — DURATION: 2 years
Due to: Senility
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work

23. SIGNATURE: John M. Caffey — Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed: 1/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

R0093

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: A. A.

City or town: Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Linthicum Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Elvaston Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mollie Elizabeth Bowersox

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widowed

6.(b) Name of husband or wife: Richard Oliver Bowersox

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 15 - 1883.

8. AGE: Years	Months	Days	If less than one day
61	4	1	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Conrad Tiemper

13. Birthplace: Germany

MOTHER 14. Maiden name: Marie Elizabeth Feuerbacher

15. Birthplace: Germany

16. Informant: Mrs. Mary C. Hemph

Address: N. Linthicum Md.

17. Buried (Burial, cremation, or removal, Which?) Date thereof 1/20/45 (month) (day) (year)

Cemetery or crematory: Mt. Carmel

Location: Baltimore Md.

18. Funeral director: Millhorn Funeral Home

Address: 1219 E. Fort Ave.

19. 1/17 45 (Date rec'd by registrar) A. W. Helfrich per M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16 1945, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20 1944, to Jan. 16 1945 and that I last saw h.... alive on Jan. 16 1945

Immediate cause of death	DURATION
Cardio Vascular Disease	1 yr.
Due to Arteriosclerosis	5 yr.
Due to Hypertension	10 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. L. Bare Jr. M.D. M. D. or other

Address: Linthicum Md. Date signed 1-16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd. U.S.
1/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

00694 F

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Gruenland Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Anne Arundel
City or town Gruenland Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Charles H Brock

3. (b) Social Security Number none

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Elsie
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Nov 11 1871
8. AGE: Years 73 | Months 2 | Days 4 | If less than one day: ..... hrs. ..... min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Pattern Maker Retired
11. Industry or business:
12. FATHER — Name: Christian Brock
13. FATHER — Birthplace: Germany
14. MOTHER — Maiden name: Anna M Grill
15. MOTHER — Birthplace: Germany
16. Informant: Roland Brock
Address: Gruenland Beach
17. Burial, cremation, or removal, Which?: Burial — Date thereof 1/18/45 (month) (day) (year)
Cemetery or crematory: Maulond Town
Location: Baltimore County Md
18. Funeral director: Milburn Cook Inc
Address: 1214 E Coul St
19. (Date rec'd by registrar) 1-16 1945 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1945, at 10:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1945, to Jan 15 1945 and that I last saw h... alive on Jan 15 1945

Immediate cause of death: (a) Coronary occlusion — DURATION: one month
Hypostatic Pneumonia
Due to: (b) Age
Due to: (c)
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Thos H Phillips M. D. or other
Address 1939 Edmondson Ave Date signed 1-15-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00695 P

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Millersville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Millersville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cecil Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Minnie Brown

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8 1869

8. AGE:

Years	Months	Days	If less than one day
75	6	1	hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: John Brown
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary E. Woodward
15. Birthplace: Md.

16. Informant: Mrs. Ira Downs
Address: Millersville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12 1945 (month) (day) (year)
Cemetery or crematory: Baldwin Mem.
Location: Millersville Md.

18. Funeral director: George Leinbach
Address: 525 N. Lyndhurst St

19. 1/11 19 45 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9 19 45, at 4 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 - 45 19 to Jan 9 - 45 19
and that I last saw h alive on Jan 8 - 45 19

Immediate cause of death	DURATION
Lobar Pneumonia.	3 days
Due to:	
Due to:	
Other conditions: Anemia.	2 days

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. D. or Coroner
Address: Date signed: 1-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

00096 P

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Q. A.

City or town: P. Towers Pk. Brooklyn 25 -
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Q. A.

City or town: P. Towers Pk - Brooklyn 25
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Huffman & Taylor Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Rosie E. Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col	Widowed

6.(b) Name of husband or wife: Rev J. Brown

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 26 - 1882

8. AGE: Years	Months	Days	If less than one day
62	4	12	____ hrs. ____ min.

9. Birthplace: Calvert Co. Md.
(Town, county, and state)

10. Usual occupation: Home work

11. Industry or business:

FATHER 12. Name: Thomas Grant

13. Birthplace: Md

MOTHER 14. Maiden name: Rachel ?

15. Birthplace: Md

16. Informant: Lloyd Gray

Address: Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/12/45 (month) (day) (year)

Cemetery or crematory: Patuxent Cemetery

Location: Prince Geo. Co. Md.

18. Funeral director: Geo. H. Nelson

Address: 1303 Pennsylvania Ave.

19. 1-10 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 8 1945, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938 to Jan 8 1945 and that I last saw h- alive on Jan 8 1945

Immediate cause of death	DURATION
Cardio-vascular Disease	5 yr.
Due to	
Due to	
Other conditions	
Arteriosclerosis	8 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Chas. L. Bailey Jr. M.D.
M. D. or other

Address: Lothian Date signed 1-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of cause of death is shown on FILM No. G 9 4 APR 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00697

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Simms Crossing, Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred:
Simms Crossing, Annapolis Md.
How long in hospital or institution? XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Simms Crossing, Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Simms Crossing
(If rural, give LOCATION)
2.(a) If veteran, name war: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

3.(a) FULL NAME: Viola Pindell Brown

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Anothy Brown
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): August 28, 1910

8. AGE: Years	Months	Days	If less than one day
34 34	4		..... hrs. ..... min.

9. Birthplace: Washington D. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Alfred Pindell
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden name: Edith Branford
15. Birthplace: Unknown

16. Informant: Anothy Brown
Address: Simms Crossing, Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/9/45 (month) (day) (year)
Cemetery or crematory: Breur Hill Cemetery
Location: West St. Extd.

18. Funeral director: Ethel L. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Jan. 9 1945 (Date rec'd by registrar) Wm. Dench Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/5 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/5 1945, to ..... 19..., and that I last saw her alive on 1/5/45 19...

Immediate cause of death	DURATION
Cardiac Failure.	
Due to Mitral insufficiency. C.H.D.	
Duration 2 years	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Theodore A. Johnson M.d M. D. or other
Address: 35 Northwest St. Date signed: 1/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

00698

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? March 29, 1933

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? Since March 29, 1933

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1259 E. Lexington Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: BYRD-AMANDA

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	Sep

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): [illegible] 1877

8. AGE:

Years	Months	Days	If less than one day
67	Unknown		hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: -------

FATHER
12. Name: George W. Presbery
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Harriett Imay
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-13-45 (month) (day) (year)

Cemetery or crematory: Mt. Lebanon

Location: Baltimore, Md.

18. Funeral director: William A. Jackson

Address: 916 Penna. Ave, Balto. Md.

19. Jan 9 1945 (Date rec'd by registrar) E.T. Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1945, at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29, 1933, to Jan. 6 1945 and that I last saw h[illegible]er alive on January 6, 1945

	DURATION
Immediate cause of death: Apoplexy	Since Jan. 3 1945
Due to:	
Due to: General arteriosclerosis & diabetes mellitus	About 8 yrs.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert Brodbeck M. D. or other

Address: Crownsville, Maryland Date signed: 1/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00699

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 hours
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If a newborn infant give residence of mother)
State: Maryland County: Anne Arundel
City or town: P.O. Annapolis R.F.D. No. 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Defense Highway near (If rural, give location) Severna
2.(a) If veteran, name war:

3.(a) FULL NAME: Vernon Robert Cole

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 30th 1938

8. AGE: Years	Months	Days	If less than one day
6	3	12	hrs. min.

9. Birthplace: A. A. Co. Md. (Town, county, and state)
10. Usual occupation: School
11. Industry or business
FATHER 12. Name: William L. Cole
FATHER 13. Birthplace: A A Co Md.
MOTHER 14. Maiden name: Alice Brandenburg
MOTHER 15. Birthplace: Carroll Co Md.
16. Informant: Wm L. Cole
Address: Defense Highway A A Co Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Janu 15th 1945 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cmt
Location: Annapolis Md
18. Funeral director: John M. Taylor
Address: Annapolis Md.
19. Jan. 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 1945 at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination ~~to~~ January 12 1945 ~~and that I last saw him alive on~~

Immediate cause of death	DURATION
Fracture of Skull	22 Hours
Due to: Automobile Collision	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 1/11/45
Where did injury occur? Near Annapolis (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): Defense Highway
Means of injury: Hit by automobile Injured at work?

23. SIGNATURE: John M. Caffy Deputy Medical Examiner M. D.
Address: Annapolis, Md Date signed: 1/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-P)

00100

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: AnnenArundel Co.

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 years

Hospital, institution, or street address where death occurred:

Emergency Hospt.

How long in hospital or institution? 2 Monthe

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residance of mother)

State: Maryland County: AnneeArundel Co.

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 65 Northwest St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ××××××××××××××

3. (a) FULL NAME: John Corprew

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife: ××××××××××××××××××××

6.(c) If alive, give age: ××××years

7. Birth date of deceased (mo., day, yr.): January 12, 1904

8. AGE: Years	Months	Days	If less than one day
41 41			....hrs. ....min.

9. Birthplace: Annapolis Md. A. A. Co.
(Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: None

FATHER
12. Name: George Corprew
13. Birthplace: Virginia

MOTHER
14. Maiden name: Annie Corprew
15. Birthplace: Prince George Co.

16. Informant: Mrs Marie Chase

Address: 10 Clay St. Annapol is Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/25/45 (month) (day) (year)

Cemetery or crematory: Breur Hill Cemetery

Location: West Street Extd.

18. Funeral director: Ethel L. Hicks

Address: 45 Northwest St. Annapolis Md.

19. Jan. 25 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 22 19 45, at 11 50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 19 44 to Jan 22 19 45 and that I last saw h-- alive on Jan 22 19 45

Immediate cause of death	DURATION
shock - (operation)	1 hr.
Due to resecting q stomach	
Due to Carcinoma of stomach	8 mos.
Other conditions Syphilis - Lab Latent	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ruptured Ca stomach into pancreas & lesser omental cavity Date of op. 1/22/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: S-Bowsuch MD M. D. or other

Address: Annapolis Md Date signed: 1/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

00161 28

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? four days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? four days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown (If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown (If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: COURSE - SARAH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
70 (?)	----	---	---- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: unknown

FATHER 12. Name: unknown

FATHER 13. Birthplace: unknown

MOTHER 14. Maiden name: unknown

MOTHER 15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 2-9-45 (month) (day) (year)

Cemetery or crematory: Hospital Cemetery

Location: Crownsville State Hospital

18. Funeral director: Cupp

Address: Crownsville, Maryland

19. Feb. 9 1945 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29 19 45 at 3:00p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26 19 45 to January 29 19 45 and that I last saw her alive on January 29 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	since 1/26/45
Due to: -----	
Due to: -----	
Other conditions: -----	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.: ----

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ----

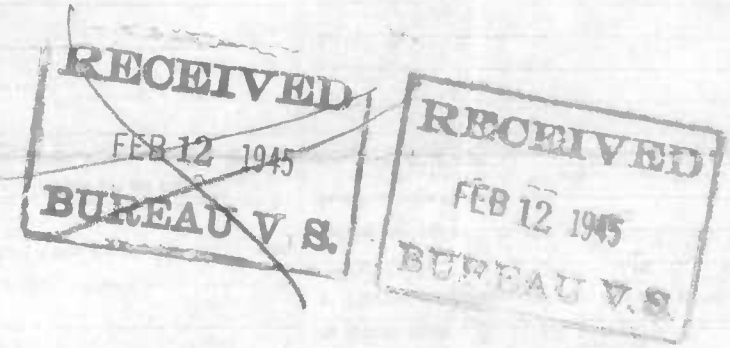
Where did injury occur? ---- (City or town) ---- (County) ---- (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Robert V. Hoffecker M. D. or other

Address: Crownsville, Maryland Date signed: 1/29/45


RECEIVED
FEB 12 1945
BUREAU V S.
RECEIVED
FEB 12 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00103

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: A. A. Co.
City or town: Dorsey, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred: Hanover, Md. R. 7 D
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Dorsey, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hanover, Md. R. 7 D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rufus H. Bailey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Married

6.(b) Name of husband or wife: Florence Bailey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 19th 1886

8. AGE: Years	Months	Days	If less than one day
59	0	20	hrs. min.

9. Birthplace: A. A. Co., Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Rail-road.

FATHER
12. Name: Nathan Bailey
13. Birthplace: A. A. Co., Md.

MOTHER
14. Maiden name: Mary Saunders
15. Birthplace: A. A. Co., Md.

16. Informant: Florence Bailey
Address: Hanover, Md., R. 7 D.

17. Buried (Burial, cremation, or removal? Which?) Date thereof: Jan. 12th 1945 (month) (day) (year)
Cemetery or crematory: Saunders
Location: Saunders, Md.

18. Funeral director: Kate Williams
Address: Schroeder St., Baltimore Md.

19. Jan 10 1945 (Date rec'd by registrar) Clara Kaslick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9th 1945, at 1.10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1st 1944, to Jan. 9th 1945, and that I last saw him alive on Jan. 8th 1945

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular Disease	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓
Date of op.
Autopsy results: ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Shipley, M.D. M. D. or other
Address: Savage, Md. Date signed: 1/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for changes of items 6B and 8C,, 9, 12, 14, Film G92 1-23-45. L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

CERTIFICATE OF DEATH

P 00102

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town North Linthicum
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town N. Linthicum
(If outside city or town limits, write RURAL and give nearest town)
Street No. 23 Patapsco Rd
(If rural, give LOCATION)
2.(a) If veteran, name war W

3.(a) FULL NAME Charles W. de Sambourg.

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Golda K. B.
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Dec 1, 1883

8. AGE:

Years	Months	Days	If less than one day
61	1	16	hrs. min.

9. Birthplace Dillsburg (Dillon) Penn
(Town, county, and state)
10. Usual occupation Auditor
11. Industry or business U.S. Govt
FATHER 12. Name Charles de Sambourg
13. Birthplace Ohio
MOTHER 14. Maiden name Elizabeth Carrington
15. Birthplace Mississippi
16. Informant Mona Stinchcomb
Address N. Linthicum Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/20/45 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Brooklyn Md
18. Funeral director Milburn Funeral Home
Address 1219 E. Fort Ave.
19. 1/19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1945, at 9:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec - 1944, to Jan 17 1945
and that I last saw him alive on Jan. 17 1945

	DURATION
Immediate cause of death Carcinoma Lungs -	1 yr.
Due to	
Due to	
Other conditions Possible Tuberculosis -	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the causes to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr MD
M. D. or other
Address Linthicum Date signed 1-19-45

00104

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: 36 Monroe Court
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Annapolis Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frederick C. Dreyer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emily B. Dreyer
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 4th 1888

8. AGE:	Years	Months	Days	If less than one day
	56	10	1	....hrs. ....min.

9. Birthplace: Denmark
(Town, county, and state)
10. Usual occupation: Barber
11. Industry or business:
12. Name of father: —
13. Birthplace of father: Unknown
14. Maiden name of mother: —
15. Birthplace of mother: —
16. Informant: Emily B. Dreyer
Address: 36 Monroe Court Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 9th 1945 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.
18. Funeral director: John M. Sayler
Address: Annapolis Md.
19. Jan 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1945 at 1 25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1945 to Jan 6 1945 and that I last saw him alive on Jan 6 1945

Immediate cause of death	DURATION
acute dilatation of heart	3 days
Due to: arteriosclerotic cardio-vascular disease	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ..... Injured at work?

23. SIGNATURE: S. Bonsuch MD
M. D. or other
Address: Annapolis Md Date signed: 1/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

00165

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A. A.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 87 Dean

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Durner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 6 - 1945

8. AGE: Years | Months | Days: 1 | If less than one day: 3 hrs. ..... min.

9. Birthplace: Annapolis, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: James A Durner

13. Birthplace: Annapolis, Md

MOTHER

14. Maiden name: Patricia V Kimball

15. Birthplace: Annapolis Md

16. Informant: James A. Durner

Address: Annapolis, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 8/45 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: Annapolis, Md

18. Funeral director: B. L. Hopkins

Address: Annapolis, Md

19. Jan. 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7 1945, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1945, to Jan 7 1945

and that I last saw h[illegible] alive on Jan 7 1945

Immediate cause of death	DURATION
1 2 weeks premature (s)	
Due to Atelectasis	1 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C Braid M. D. or other

Address: Annapolis Md Date signed 1-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

00106 P

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH
County Anne Arundel
City or town Jessups
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Anne Arundel
City or town Jussups
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bessie Gaither

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Benjamin Gaither
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 16, 1892

8. AGE: Years	Months	Days	If less than one day
52	1		..... hrs. ..... min.

9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Stevens Hubron
13. Birthplace P. G. Co., Md.
MOTHER 14. Maiden name Mary E. Tyler
15. Birthplace P. G. Co., Md.
16. Informant Mr. Benjamin Gaither
Address Jessups, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-10-45 (month) (day) (year)
Cemetery or crematory Williams Cem.
Location Harmons, A. A. Co., Md.
18. Funeral director Mrs. Frances A. Hemsley
Address 578 W. Biddle St.
19. 1 8 45 (Date rec'd by registrar) J. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 7 1945 at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 5 1945 to 1 7 1945 and that I last saw her alive on 1 7 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 5 45
Hypertension	1 4 43
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B P Warren M. D. or other
Address Laurel Md Date signed 1 8 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-1

00167

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Mayo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Mayo
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Ruth Harriet Norris Gardner

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married.

6.(b) Name of husband or wife James Wesley Gardner
6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) April 27 1895

8. AGE: Years	Months	Days	If less than one day
49	8	27	...hrs. ...min.

9. Birthplace Penna.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Harry L. Norris
13. Birthplace Huntingdon Pa.

MOTHER
14. Maiden name Susan A. Gutshall
15. Birthplace Three Springs, Pa.

16. Informant James W. Gardner
Address Mayo Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 1/28/45 (month) (day) (year)
Cemetery or crematory Mayo Methdoist
Location Mayo Md.

18. Funeral director T. A. Hardesty & Son
Address Galesville Md.

19. Jan 28 1945 Edw Collinson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945 at 7 20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to Jan 24 1945 and that I last saw h... alive on Jan 23 1945

Immediate cause of death	DURATION
rupture d aortic aneurism	—
Due to syphilitic aortitis	6 yrs (?)
Due to	
Other conditions Cardiac dilatation	6 mos
myocardial insufficiency	6 mos

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J Bosomworth M.D
M. D. or other
Address Annapolis Md Date signed 1/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00168

CERTIFICATE OF DEATH

Reg. Diat. No. 23

1. PLACE OF DEATH:

County: Linthicum Heights A.A.Co.

City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
208 W. ~~Longwood Rd.~~ Fremont Rd.

How long in hospital or institution? 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4129 Forest Park Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

Sallie Curtis Garrett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Frank Lee Garrett

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 11, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	-	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John B. Hill
13. Birthplace: New Hampshire

MOTHER
14. Maiden name: Ellen Keeble
15. Birthplace: Va.

16. Informant: Mr. Curtis L. Garrett
Address: 208 W. Greenwood Rd. Linthicum Hgts

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/13/45 (month) (day) (year)

Cemetery or crematory: Druid Ridge

Location: Pikesville Md.

18. Funeral director: William J. Tickner & Sons

Address: North & Pa. Aves.

19. 1/13 19 45 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11, 1945 19 at 2/30 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1, 1945, to Jan 11 1945

and that I last saw h[er] alive on Jan 16 1945

Immediate cause of death	DURATION
Carcinoma of the Lung	6 months
Due to: Carcinoma of the Uterus	1 year.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James S. Beilinson M.D.
M. D. or other

Address Date signed

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

P 00109

Reg. Dist. No. 28

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Townsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months + days

Hospital, Institution, or street address where death occurred:

Townsville State Hospital

How long in hospital or institution? 2 months + days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 925 N. Carey St.

(If rural, give LOCATION)

2.(a) If veteran, name war: non

3.(a) FULL NAME: Clarence E. Hall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: ~~[illegible]~~ Lucy Goodes

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): unknown May 3, 1887

8. AGE: Years	Months	Days	If less than one day
57	8	—	....hrs. ....min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: Funeral Home

FATHER 12. Name: Marshall Hall

FATHER 13. Birthplace: Maryland.

MOTHER 14. Maiden name: unknown

MOTHER 15. Birthplace: Va.

16. Informant: Hospital Records

Address: Townsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 6. 45. (month) (day) (year)

Cemetery or crematory: Arbutus Cemetery

Location: Arbutus Md.

18. Funeral director: John O. Mitchell & Son

Address: 1900 Eutaw Place, Balto

19. 1 5 '45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 1945 at 5 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30 1944 to January 3 1945 and that I last saw him alive on January 3, 1945

Immediate cause of death	DURATION
General Paresis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. K. Schmidt M. D. or other

Address: Townsville Md. Date signed: 1/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (86)

00110

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A A

City or town Parole, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A-A-

City or town Parole
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur Harris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	—

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1944

8. AGE: Years	Months	Days	If less than one day
	2	28	..... hrs. ..... min.

9. Birthplace ~~Parole Md.~~ Wash. D. C.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Authur Harris Sr.

13. Birthplace md.

MOTHER 14. Maiden name Catherine Johnson

15. Birthplace Parole md.

16. Informant Catherine Johnson

Address Parole md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 3, 1945 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis md.

18. Funeral director J.B. Johnson

Address Annapolis md.

19. Feb. 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1945 at 11 30 A.M.

21. I CERTIFY that death occurred on the date above stated, ~~and that I last saw him alive on~~ Postmortem Examination January 31 1945

Immediate cause of death	DURATION
Convulsions	sudden
Due to Congenital debility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE John M. Cleffy Deputy Medical Examiner M. D. or Coroner

Address Annapolis, Md. Date signed 2/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00111 28

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since June 4, 1943
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? Since June 4, 1943

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1012 North Durham St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HARRISON-MAGGIE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	M

6.(b) Name of husband or wife: Mr. Israel Harrison
6.(c) If alive, give age: ------ years

7. Birth date of deceased (mo., day, yr.): 1918

8. AGE: Years: 26 | Months: Unknown | Days: | If less than one day: hrs. min.

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: -----

FATHER
12. Name: Ben Stevenson
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Hattie Bell
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/11/45 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Cedar Hill Maryland
16. Funeral director: Elmo O'Wilson
Address: 1500 Baltimore Avenue

19. 1/7-45 (Date rec'd by registrar) 19 Ethel Joyce Rose Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 1945, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4, 1943, to Jan. 7 1945 and that I last saw her alive on January 7 1945

	DURATION
Immediate cause of death: General Paresis	Since June 4 1943
Due to:	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Ethel V. Hamlock M. D. or other
Address: Crownsville, Maryland Date signed 1/7/45

Ⓜ

STATE OF MARYLAND—CERTIFICATE OF DEATH

00112
23

1. PLACE OF DEATH (45 d)

County Anne Arundel Registration Dist. No.

Village or City Brooklyn No. 4408 Fourth St. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME James N. Harvey

(a) Residence: No. 4408 4th St. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS		
3. SEX: M.	4. COLOR OR RACE: White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine McBride

6. DATE OF BIRTH (month, day, and year) 8/2/1884

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	60	5	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Ship Joiner

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Coast Guard

10. Date deceased last worked at this occupation (month and year) ____ 11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) (State or country) Ireland

FATHER

13. NAME Wm Harvey

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME Eliz Calvin

16. BIRTHPLACE (city or town) (State or country) Ireland

17. INFORMANT Mrs J. N. Harvey
(Address) 4408 Fourth St.

18. BURIAL, CREMATION, OR REMOVAL
Place Cathedral Date 1/12 1945

19. UNDERTAKER John J. Stakem & Sons
(Address) 1318 Light St.

20. FILED 1/11 1945 [illegible]
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 8 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1944, to Jan 8, 1945

I last saw him alive on Jan 6, 1945; death is said to have occurred on the date stated above, at 4 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Cardiac thrombosis — Date of onset 1/8/45

Other Contributory Causes of importance: Superior maxillary carcinoma — 4 mos

Name of operation removal of maxillary bone Date of

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19__

Where did injury occur? ____
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. F. [illegible] M. D.

(Address) [illegible] Randall St.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

Ⓣ

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

00113

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
214 Clay st
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 214 Clay st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clarent Hicks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 28 1945

8. AGE: Years ..... Months ..... Days ..... If less than one day ..... 1 hr ..... min.

9. Birthplace Annapolis
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Joseph Hicks
13. Birthplace Md

MOTHER
14. Maiden name Teresa Harris
15. Birthplace Md

16. Informant Joseph Hicks
Address 214 Clay st

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Jan 30 1945 (mooth) (day) (year)
Cemetery or crematory Bruce Hill
Location Annapolis

18. Funeral director J. B. Johnson
Address Annapolis

19. Jan 29 45 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 1945 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1945 to Jan 28 1945 and that I last saw h.... alive on Jan 28 1945

Immediate cause of death	DURATION
Skull Fracture (Traumatic)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE B. F. Richardson M. D.
M. D. or other
Address Annapolis, Md. Date signed 1/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

00114

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a. a.

City or town: Selby on the Bay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a. a.

City or town: Selby on the Bay

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near Mayo

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Cora Edna Hunter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Emmett L Hunter

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): June 1 — 1876

8. AGE: Years	Months	Days	If less than one day
68	8	12	....hrs. ....min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business:

FATHER — 12. Name: John Limbach

FATHER — 13. Birthplace: Pa

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Emmett L. Hunter

Address: Selby on the Bay

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 16 / 45 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Suitland, Maryland

18. Funeral director: B. L. Hopping

Address: Annapolis, Maryland

19. Jan. 15 1945 Edward Collenson

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12 1945 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 6 1945 to Jan 12 1945

and that I last saw h[er] alive on Jan. 11 1945

Immediate cause of death	DURATION
Myocardial failure	
Due to hypertension	
Due to arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D.

M. D. or other

Address: Lothian, Md. Date signed: 1/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

00115

Reg. Dist. No. 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 Gloucester St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ellen Talia Ferro Jenkins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 9th 1851

8. AGE:

Years	Months	Days	If less than one day
93	3	13	..... hrs. ..... min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual occupation gentle woman
11. Industry or business
12. FATHER Name George Taylor Jenkins
13. FATHER Birthplace Baltimore, Md
14. MOTHER Maiden name Elizabeth H. Barrett
15. MOTHER Birthplace Baltimore, Md
16. Informant Mrs. George Kiester
Address 110 Gloucester St, Annapolis
17. Burial Date thereof Jan 24, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md
18. Funeral director John M. Taylor
Address Annapolis, Md
19. Jan 23 1945 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1945 at 6.50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Jan 22 1945 and that I last saw h.. alive on Jan 22 1945

	DURATION
Immediate cause of death Uraemia	5 Day
Due to Senile Arterio Sclerosis	Years
Due to Cr. Nephritis	Several Yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Ellen Purvis M. D. or other
Address Annapolis, Md Date signed 1/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00116

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital or Institution, or street address where death occurred: Old Annapolis Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Severna Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Geneva Jennings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Colored	Widowed

6.(b) Name of husband or wife: Clinton Jennings
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): May 7 1888

8. AGE: Years	Months	Days	If less than one day
56.	8	13	hrs. min.

9. Birthplace: A. A. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
FATHER 12. Name: James Morgan
13. Birthplace: Md.
MOTHER 14. Maiden name: Charlotte Morgan
15. Birthplace: Md
16. Informant: Clinton Jennings
Address: Severna Park
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 23/45 (month) (day) (year)
Cemetery or crematory: Townsend
Location: Severna Park
18. Funeral director: J. B. Johnson
Address: Annapolis
19. Jan. 23 1945 (Date rec'd by registrar) L. A. Dreier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 20 1945, at 10:40 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/23 1944 to Jan 20 1945
and that I last saw h. alive on Jan. 19. 1945

	DURATION
Immediate cause of death	
Carcinoma of Stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Theodore H. Johnson M. D.
M. D. or other
Address 35 Northern Ave. Date signed 1/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

00117

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural - Chesterfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Crownsville P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Chesterfield Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Martha Lena Jennings

3.(b) Social Security Number:

4. Sex: female
5. Color or race: negro
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: John Jenning
6.(c) If alive, give age: 71 years
7. Birth date of deceased (mo., day, yr.): Feby. 17, 1879
8. AGE: Years: 65 Months: 11 Days: 8 If less than one day: hrs. min.
9. Birthplace: Chesterfield, Anne Arundel Co, Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: not known
13. Birthplace:
MOTHER 14. Maiden name: Martha L. Johnson
15. Birthplace: Chesterfield, Maryland
16. Informant: John Jennings
Address: Chesterfield Road, Crownsville, R.D. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany. 30 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olive
Location: Chesterfield Road
18. Funeral director: J. S. Johnson
Address: Annapolis Md
19. Jan. 29 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 26 1945, at 9 05 A.M.
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination 19..; to 19.. and that I last saw ~~him~~ alive on Jany. 26, 1945

	DURATION
Immediate cause of death: Acute Dilation of Heart	a few hrs
Due to: Chronic Myocarditis	4 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Clapp M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 1/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

00118

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, Institution, or street address where death occurred: Wells Ave. Simms Crossing

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Annee Arundel

City or town: Simms Crossing, Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Wells Ave. Simmms Crossing

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Daniel Johnson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife: ********************

6.(c) If alive, give age: ***** years

7. Birth date of deceased (mo., day, yr.): March 1869

8. AGE: Years	Months	Days	If less than one day
75 75	10		hrs. min.

9. Birthplace: A. A. Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: None

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: James Wells

Address: Wells Ave. Simms Crossing, Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/10/45 (month) (day) (year)

Cemetery or crematory: Mews Chapel Cemetery

Location: Dunkirk Md.

18. Funeral director: Ethel L. Hicks

Address: 45 Northwest St. Annapolis Md.

19. Jan. 10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8, 1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19th 1944 to Jan 8, 1945 and that I last saw h[illegible] alive on Jan 8, 1945

Immediate cause of death	DURATION
Heart Failure	
Due to Acute Myo-Cardial	1 month
Due to	
Other conditions Arterio - Sclerosis	1 Year

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other

Address: 110 Duke of Gloucester St. Date signed: 1/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

00119

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 years
Hospital, institution, or street address where death occurred: 60 Clay St.
How long in hospital or institution? **********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 60 Clay St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Elijah Johnson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Widower

6.(b) Name of husband or wife: **********

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9, 1870

8. AGE:	Years	Months	Days	If less than one day
	74	7		..... hrs. ..... min.

9. Birthplace: Annapolis Md. (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: None

FATHER
12. Name: Alfred Johnson
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden name: Eliza Wilson
15. Birthplace: A. A. Co. Md.

16. Informant: Mrs Margret Bryant
Address: 179 Clay St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/ 12/ 45 (month) (day) (year)
Cemetery or crematory: Breur Hill Cemetery
Location: West St. Extd.

18. Funeral director: Ethel L. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Jan. 12 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 8 19 45, at 10 30 A M

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination

and that I last saw deceased alive on Jany. 8 19 45

Immediate cause of death: Acute dilatation of Heart — Duration: sudden

Due to: Arteriosclerosis — Duration: uncertain

Due to: Chronical Hypertension — Duration: uncertain

Other conditions: — Duration:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John McCaffy Deputy Medical Examiner M. D.
Address: Annapolis Md. Date signed 1/11/45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00120 218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since June 8, 1925

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? Since June 8, 1925

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No.: 18 N. Gilmore Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JOHNSON-SAMUEL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	B	M

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1885

8. AGE: Years	Months	Days	If less than one day
59	Unknown		hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER — 12. Name: Reuben Johnson

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 15, 1945 (month) (day) (year)

Cemetery or crematory: Mt Auburn Cem

Location: Baltimore

18. Funeral director: Mrs Katie Williams

Address: 322 N. Schroeder St.

19. 1-10-45 (Date rec'd by registrar) 19 [illegible] Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH: January 10 19 45 at 9:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8, 19 25 to Jan. 10 19 45

and that I last saw him alive on Jan. 10, 19 45

Immediate cause of death	DURATION
Arteriosclerosis	Unknown
Due to: Chronic myocarditis	Unknown
Due to:	
Other conditions: Marked mental deficiency	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Herb V. Smith M. D. or title 1/10/45

Address: Crownsville, Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3Fa)

CERTIFICATE OF DEATH

00121

Reg. Diat. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Drury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: A.A.
City or town: Drury
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) 2
2.(a) If veteran, name war

3.(a) FULL NAME Omma Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Married

6.(b) Name of husband or wife: William E. Jones
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 1st, 1889

8. AGE: Years: 55 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER
12. Name: Andrew Smith
13. Birthplace: Md.

MOTHER
14. Maiden name: Elizabeth Crawford
15. Birthplace: Md.

16. Informant: William E. Jones
Address: Drury

17. (Burial, cremation, or removal: Which?) Buried Date thereof: Jan 4-45 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cem.
Location: Marlboro. Md.

18. Funeral director: G. G. Hardesty & Son
Address: Galesville Md.

19. 1/2 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1 1945, at 1620 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1944 to Jan 1 1945
and that I last saw h[illegible] alive on Dec 30 1944

Immediate cause of death	DURATION
Cerebral Hemorrhage	8 days
Due to Hypertension	3 yrs
Due to Arteriosclerosis	10 yrs
Other conditions Nephritis	8 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James E. Jansen, M. D. or other
Address: Upper Marlboro Md. Date signed 1-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00122

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County Anne Arundel
City or town Oakwood Glen Burnie, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Oakwood Glen Burnie, P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Peter Kimmel

3.(b) Social Security Number 216-07-7666

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna R. Kimmel
nee-Kries
6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) July 10, 1871

8. AGE: Years 70 | Months 6 | Days 1 | If less than one day ... hrs. ... min.

9. Birthplace Rodebach, Germany.
(Town, county, and state)

10. Usual occupation Die Setter (Retired.)

11. Industry or business Nat'l Enameling Stamping Co.

FATHER
12. Name Martin Kimmel
13. Birthplace Germany

MOTHER
14. Maiden name Martha Holzapfel
15. Birthplace Germany

16. Informant Mrs John P. Kimmel
Address Oakwood, Glen Burnie, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 18 1945 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Anne Arundel Co. Md.

18. Funeral director Thomas W. Dugleton
Address Glen Burnie, Md

19. Jan 17 1945 (Date rec'd by registrar) Mrs Galba Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1945 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1943 to Jan 15 1945 and that I last saw h.i.m. alive on Jan. 14 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	36 hours
Due to Arteriosclerosis	1½ years
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury None Injured at work?

23. SIGNATURE Harry A. Moore M. D. or other
Address Glen Burnie Md. Date signed 1/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

00123

CERTIFICATE OF DEATH

Reg. Dist. No. 21

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 127 Charles
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frank Albert Kramer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen Kramer
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1890

8. AGE:

Years	Months	Days	If less than one day
54	3	14	hrs. min.

9. Birthplace Elizabeth N. J. (Town, county, and state)
10. Usual occupation Sheet metal worker at
11. Industry or business U. S. Naval Academy Annapolis Md.

MOTHER
12. Name Martin Kraffner
13. Birthplace New Jersey

FATHER
14. Maiden name Wilhelmina Handgardner
15. Birthplace Germany

16. Informant Mrs Helen Kramer
Address 127 Charles St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 1st 1945 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md
18. Funeral director John M Taylor
Address Annapolis Md

19. Feb. 1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1945 at 8 35 P. M

21. I CERTIFY that death occurred on the date above stated; from ~~the conditions~~ Postmortem Examination ~~and~~ ~~last saw~~ ~~alive on~~ January 29 1945

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to Coronary sclerosis	Uncertain
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Clapp Deputy Medical Examiner M. D. or other
Address Annapolis, Md. Date signed 1/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00124

CERTIFICATE OF DEATH

Reg. Diat. No. 26

1. PLACE OF DEATH:

County a a.

City or town Deale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County a a.

City or town Deale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war none

3. (a) FULL NAME Frank D. Leatherbury

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

6.(b) Name of husband or wife Sarah Jane

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 17 1865

8. AGE: Years	Months	Days	If less than one day
76	5	1	..... hrs. ..... min.

9. Birthplace Shadyside Md.

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Charles Edward Leatherbury

13. Birthplace Md

MOTHER 14. Maiden name Deale

15. Birthplace Md

16. Informant Leroy Leatherbury

Address Deale Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/19/45 (month) (day) (year)

Cemetery or crematory Deale

Location Deale Md

18. Funeral director T A Hardesty & Son

Address Deale Hardesty

19. Jan 17 1945 E. B. Dent

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1945, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 11 1945 to Jan 15 1945

and that I last saw h alive on Jan 14, 1945

Immediate cause of death Pulmonary Tuberculosis

	DURATION
Due to	
Due to	
Other conditions Myocarditis Chronic	7

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F B West M. D. or other

Address Lothian, Md Date signed 1/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-C)

CERTIFICATE OF DEATH

00125

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Generals Highway
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Generals Highway
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Franklin Madison

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rae A. Madison
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 8th 1887

8. AGE: Years	Months	Days	If less than one day
57	8	29	hrs. min.

9. Birthplace: ~~Texas~~ Belton, Missouri
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER 12. Name: Unknown
13. Birthplace

MOTHER 14. Maiden name: Unknown
15. Birthplace

16. Informant: Rae A. Madison
Address: Generals Highway A.A.C. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 9-1945 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington Va.

18. Funeral director: John M. Taylor
Address: Annapolis Md

19. Jan. 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 6th 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1944 to Jan 6 1945 and that I last saw him alive on Jan 6 1945

Immediate cause of death	DURATION
Myocarditis acute	3 days.
Due to: Carcinoma Pros Gate	1 year.
Due to: Chr. Bronchitis	
Other conditions: Bronchiectasis with cavity formation.	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Geo. C. Boyle, M. D. or other
Address: Annapolis Md Date signed: 1. 8. 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

122-C

State File No. _____
Registrar's No. 27

State of Maryland

04126

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Ft Geo G Meade (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Regional Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 Days (Specify whether years, months or days) In this community 8 Months 14 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County _____
(c) City or town Brooklyn (If outside city or town limits, write RURAL)
(d) Street No. 921 Montgomery St (If rural, give location)
(e) If foreign born, how long in U. S. A.? – years ✓

3. (a) FULL NAME May NMI Miller
3. (b) If veteran, name war –
3. (c) Social Security No. –
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Milton S Miller
6. (c) Age of husband or wife if alive – years
7. Birth date of deceased February (Month) 24 (Day) 1922 (Year)

8. AGE: Years 22 | Months 10 | Days 19 | If less than one day – hr. – min.

9. Birthplace Brooklyn, New York (City, town, or county) (State or foreign country)
10. Usual occupation Soldier
11. Industry or business U S Army

MOTHER
12. Name Martin Newman
13. Birthplace Brooklyn New York (City, town, or county) (State or foreign country)
14. Maiden name Fannie (unknown) Newman
15. Birthplace Brooklyn New York (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Service Record
(b) Address U S Army
17. (a) Transportation (Burial, cremation, or removal) (b) Date thereof 13 Jan 45 (Month) (Day) (Year)
(c) Place; burial or cremation Brooklyn, NY
18. (a) Signature of funeral director Howard M. Blight Jr.
(b) Address 4194 Belair Rd, Balti, Md
19. (a) 13 Jan 45 (Date received local registrar) (b) W J Lawson Jr. W.J.LAWSON, JR., 1st Lt (Local registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month January day 12
year 1945 hour 8 minute 29 PM
21. I hereby certify that I attended the deceased from 22 December, 1945, to 12 January, 1945 that I last saw her alive on 12 January, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary edema.	
Due to: Cause undetermined.	
Due to:	
Other conditions: Foetal intestinal obstruction (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations Foetal intestinal obstruction
Of autopsy Pulmonary edema.

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) –
(b) Date of occurrence –
(c) Where did injury occur? – (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? –
While at work? – (Specify type of place) (e) Means of injury –
23. Signature A Bischof Jr. 1st M.C. (M. D. or other)
Address Reg Hosp Ft Meade, Md Date signed 13 Jan 45

8-6917 U. S. GOVERNMENT PRINTING OFFICE 16—13493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 111127 28

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Anne Arundel

City or town Millersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Millersville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Benfield Road

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Mr. Isaac C. Morgan.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife Emma K .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 23. 1866

8. AGE:

Years	Months	Days	If less than one day
78	6	8	..... hrs. ..... min.

9. Birthplace Calvert Co Md
(Town, county, and state)

10. Usual occupation Retired Clergyman

11. Industry or business Ret. M.E.

FATHER

12. Name John Thomas Morgan

13. Birthplace Md

MOTHER

14. Maiden name Elladuna Thomas

15. Birthplace Calvert Co Md

16. Informant Mrs Anne K Morgan

Address Millersville Md

17. Burial Date thereof 1/4/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore Md

18. Funeral director Tilhom Funeral Home

Address 1217 St Paul St

19. 1/2 19 45 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1st 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1944, to 12/31/44 1944

and that I last saw h.. alive on 12/31/44 1944

Immediate cause of death	DURATION
Myocardial failure	6 hr.
Due to Hypertension	9 mos.
Due to Chronic interstitial nephritis	9 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Gustave A. Rauber D.M.D.
M. D. or other

Address Glen Burnie, Md Date signed 1/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98-2)

00128

CERTIFICATE OF DEATH

Reg. Diat. No. 2 V

1. PLACE OF DEATH
County: Anne Arundel
City or town: Dorsey
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infant, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Dorsey
(If outside city or town limits, write RURAL and give nearest town)
Street No.: near Dorsey Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Cora Noates

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	negro	married

6.(b) Name of husband or wife: Elmer Noates
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Nov. 17, 1893

8. AGE: Years: 51 | Months: 1 | Days: 17 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Dorsey, Anne Arundel Co., Md.
(Town, county, and state)

10. Usual occupation: House Keeper

11. Industry or business: Home

FATHER
12. Name: James D. Butler
13. Birthplace: Dorsey, Md.

MOTHER
14. Maiden name: Evelyn Davis
15. Birthplace: Howard County, Md

16. Informant: Elmer Noates
Address: Dorsey, Maryland

17. Burial (Burial, cremation, or removal) Date thereof: Jan 7-45 (month) (day) (year)
Cemetery or crematory: St Marks
Location:

18. Funeral director: [illegible]
Address: Laurel, Md.

19. Jan 5 1945 (Date rec'd by registrar) Clara Haskins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 3 19 45 at 1 40 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination 19.. ~~and that I last saw him alive on~~ Jany. 3 19 45

Immediate cause of death: Acute Dilatation of Heart — DURATION: Sudden

Due to: Chronic Myocarditis — DURATION: Unknown

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: John M. Cathy Deputy Medical Examiner
M. D. or other

Address: Annapolis Md. Date signed 1/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00129 28

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since April 10, 1941
Hospital, Institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? Since April 10, 1941

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Unknown County: .....
City or town: .....
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME: PARKER-LENA

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	S

6.(b) Name of husband or wife: -------

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 32 1912

8. AGE: Years: 32 | Months: Unknown | Days: | If less than one day: ....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: -------

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/23/45 (month) (day) (year)
Cemetery or crematory: Crownsville, Maryland
Location: Crownsville, Maryland

19. Funeral director: ..... Supt.
Address: .....

19. Jan 23 1945 (Date rec'd by registrar) E. F. Joyce Rose Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17, 1945 at 10: A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1941 to Jan. 17 1945 and that I last saw her alive on Jan. 17, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Since May, 1943
Due to:	.....
Due to:	.....
Other conditions: Mental deficiency (Include pregnancy within 3 months of death)	Unknown

Major findings of operations: None
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Herbert A. Hoover M. D. or other
Address: Crownsville, Maryland Date signed 1/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

00130

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Patapsco Park

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Patapsco Park

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Morgan Pettis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col	Married

6.(b) Name of husband or wife: Lillie Pettis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years	Months	Days	If less than one day
68			..... hrs. ..... min.

9. Birthplace: Va (Town, county, and state)

10. Usual occupation: Laborer & minister

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace "

MOTHER 14. Maiden name: Unknown

15. Birthplace "

16. Informant: Lillie Pettis

Address: Patapsco Park Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 14 45 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cemetary

Location: Brookland Md

18. Funeral director: Elroy O Wilson

Address: 1900 Brantley ave.

19. 1/19 19 45 Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/12 19 45, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1/5 19 45 to 1/12 19 45

and that I last saw h... alive on 1/12 19 45

Immediate cause of death	DURATION
Cerebral Apoplexy	
b. Paralysis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: B W Rhett M. D. or other

Address 2134 ..... Date signed 1/16-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore VII-B

CERTIFICATE OF DEATH

00131

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel county

City or town: Crownsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Aug. 16, 1943.

Hospital, institution, or street address where death occurred:
Crownsville State Hosp.

How long in hospital or institution? Since Aug. 16, 1943.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Baldwin Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Charles Wesley Purnell

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1919. Mo. & day unk.

8. AGE:

Years	Months	Days	If less than one day
25	--	--	..... hrs. ..... min.

9. Birthplace: Berlin, Md.
(Town, county, and state)

10. Usual occupation: Never worked.

11. Industry or business: ---

FATHER
12. Name: Chas. h. Purnell
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Records Crownsville State Hosp.
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5th 1945 (month) (day) (year)

Cemetery or crematory: Family

Location: Lyons Farm, Md.

18. Funeral director: Kenneth Stewart

Address: Salisbury, Md

19. Jan. 2 1945 (Date rec'd by registrar) Ext. Joyce Lord Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 1st. 1945, at 8.30a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 16, 1943 to Jan. 1, 1945

and that I last saw him alive on Jan. 1st 1945.

	DURATION
Immediate cause of death: Pulmonary edema	1 day
Due to:	
Due to:	
Other conditions: Spastic idiot	Life

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of .....

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: Thos. D. Hitchcock M. D. or other

Address: ..... Date signed: Jan. 1, '45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-A

CERTIFICATE OF DEATH

00132

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Mayo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death 8 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co
City or town Mayo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ←

3.(a) FULL NAME Maryland Queen.

3.(b) Social Security Number 214-05-0883

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Widowed

6.(b) Name of husband or wife Mary Queen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1879

8. AGE: Years 65 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Waterbury Md
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden name Unknown
15. Birthplace "

16. Informant Ada Holland
Address 14 Monument St

17. Burial Date thereof Jan 7 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Brewer Hill Cem
Location Annapolis, Md

18. Funeral director H. C. Hardesty & Son
Address Galesville Md.

19. Jan 4 1945 Edward Collinson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4, 1945, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post Mortem Examination ~~and that I last saw h~~ January 4 1945

Immediate cause of death	DURATION
Acute Dilatation of Heart	Sudden
Due to: Chronic Myocarditis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation .....
Date of op. .....
Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John M. Claffy Deputy Medical Examiner
M. D. or other
Address Annapolis, Md Date signed 1/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (84P)

00133 28

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Jan. 13, 1945

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? Since Jan. 13, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 537 N. Carey Street
(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME

RIDDLE-ERNESTINE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	M

6.(b) Name of husband or wife: James Riddle

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1909

8. AGE: Years: 35 | Months: Unknown | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ------

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 24, 1945 (month) (day) (year)

Cemetery or
Location: Fredericksburg, Va.

18. Funeral director: Mrs. Katie L. Williams
Address: 322 N. Schroeder St.

19. 1/24 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19, 1945, at 3:10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 13, 1945 to Jan. 19, 1945 and that I last saw h...er alive on Jan. 19 1945

	DURATION
Immediate cause of death: Exhaustion (010-712)	
Due to: Schizophrenia Excitement	Prior to 1/13/45
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed 1/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

00134

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? dead (5 minutes after arrival)

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 15 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.: 6 College Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Martha Robinson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years	Months	Days	If less than one day
65 65			..... hrs. ..... min.

9. Birthplace: Hansville Md. (Town, county, and state)

10. Usual occupation: Housewife Cook

11. Industry or business: Home

MOTHER FATHER

12. Name: Unknown

13. Birthplace: Unknown

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Charles Robinson

Address: 707 N. Calhoun St Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/11/45 (month) (day) (year)

Cemetery or crematory: Forest Hill Ameteri

Location: West St Rd.

18. Funeral director: Chas F. Hicks

Address: 45 Northwest St Annapolis Md.

19. Jan. 10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 5 1945 at 5 25 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination 19.. ~~to~~ 19.. and that I last saw h... alive on Jany. 5 1945

Immediate cause of death	DURATION
Acute Dilatation of Heart	sudden
Due to Chronic Myocarditis	unknown
Due to Arterio Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: John M Cafe Deputy Medicale Examiner M. D. or other

Address: Annapolis Md. Date signed 1/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

00135

CERTIFICATE OF DEATH

Reg. Dist. No. 28

*Chixamony

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since December 6/38

Hospital, Institution, or street address where death occurred:
Crownsville, Maryland

How long in hospital or institution? Since December 6/38

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Chicamuxen
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SAVOY -ESTELLE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	M

6.(b) Name of husband or wife: Earl Savoy

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1902

8. AGE:

Years	Months	Days	If less than one day
43	Unknown		hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: -----

FATHER
12. Name: Frank Swann
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. Ward
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal, which?) Date thereof: Jan. 4 1945 (month) (day) (year)

Cemetery or crematory: Chiswynndy md

Location: Charles County

18. Funeral director: Stanley Penny

Address: Mason Springs Md

19. 1-2-45 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2 19 45, at 3:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 6, 19 38 to January 2 19 45

and that I last saw her alive on January 2, 19 45

	DURATION
Immediate cause of death: Lobar Pneumonia	Since December 31/44
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Date signed

Evidence for change of year of birth of deceased is shown on FILM No. G 94 MAY 14 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

00136

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Harwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth P. Shepherd

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Mc Lean Sheppard
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): January 10, 1865 - 1880
8. AGE: Years: 65 Months: 0 Days: 11 If less than one day ..... hrs. ..... min.
9. Birthplace: West River, A.A. Co., Md (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: Frank Welch
13. Birthplace: A.A. Co., Md

MOTHER
14. Maiden name: Elizabeth P. Wayson
15. Birthplace: A.A. Co, Md

16. Informant: Mc Lean Sheppard, Sr.
Address: Harwood, A.A. Co., Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 23, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: Anne Arundel Co.
18. Funeral director: John M. Taylor
Address: Annapolis, Md.
19. Jan. 23 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 21 1945 at 5 45a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1941 to Jan 21 1945 and that I last saw h er alive on Jan 20 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	3 hrs.
Due to: arteriosclerotic cardiovascular disease	20 yrs.
Due to:	
Other conditions: diabetis mellitus	30 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: S. Brownell, M.D. M. D. or other
Address: Annapolis Md Date signed 1/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on FILM No. G 9 4 MAY 14 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00137

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A A
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A A
City or town 165 West St.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Annapolis Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William T. Shipley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Bessie L Shipley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 4th 1870

8. AGE: Years 74 | Months 5 9 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace A A Co Md (Town, county, and state)

10. Usual occupation Store Keeper at

11. Industry or business Camp Meade

FATHER 12. Name Frank Shipley
13. Birthplace A A Co Md.

MOTHER 14. Maiden name Elizabeth Gardner
15. Birthplace A A Co Md

16. Informant Mrs Basil Moore
Address 1065 Cherry Grove Ave City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jany 18/1945 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md

18. Funeral director John M Taylor

Address Annapolis Md

19. Jan. 18 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16th 1945, at 1.30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 11th 1945, to Jan 16 1945; and that I last saw him alive on Jan 16 1945

Immediate cause of death	DURATION
Carcinoma of Cervix	Months
Due to	
Due to	
Other conditions Probable Cancer of Bladder	same Month

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Avery Parvis M. D. or other

Address Annapolis Md. Date signed 1/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-2)

00138

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Johnsontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME unnamed ~~stillborn~~ infant Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Negro	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) I-10-45

8. AGE: Years | Months | Days | If less than one day: hrs. 10 min.

9. Birthplace Johnsontown. A. A. Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Wm. Henry Smith
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden name Grace G. Johnson
15. Birthplace A. A. Co., Md.

16. Informant Wm. H. Smith
Address P. O. Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof I-11-45 (month) (day) (year)
Cemetary or crematory Magothy Cemetery
Location A. A. Co., Md.

18. Funeral director Geo. T. Lee
Address P. O. Pasadena, Md.

19. 1-10 19 45 L. A. Dreis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 19 45 at 7.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death ~~stillbirth~~ (delay of after-coming head in breech presentation) — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. A. Dreis, M. D.
M. D. or other
Address Pasadena Md Date signed 1-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

00139

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH

County A. A. County

City or town Marley Neck Rd Glenburnie Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County A. A. County

City or town Glenburnie (If outside city or town limits, write RURAL and give nearest town)

Street No. Marley Neck Road. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles E Smith.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Married.

6.(b) Name of husband or wife Mary Smith. 6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-18-1880

8. AGE: Years	Months	Days	If less than one day
64	8	14	...hrs. ...min.

9. Birthplace A. A. County Md (Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business

FATHER 12. Name Edward Smith

13. Birthplace Md

MOTHER 14. Maiden name Martha Wright

15. Birthplace Md

16. Informant Mary Smith

Address Marley Neck Rd Glenburnie Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 (month) 4 (day) 45 (year)

Cemetery or crematory Magothy Cem

Location Pasadena Md

18. Funeral director William A. Jackson

Address 916 Penrod ave

19. Jan 3 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1st 1945; at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/25/44 to 1/1/45 and that I last saw h.. alive on 12/31/44

Immediate cause of death	DURATION
Coronary Thrombosis	one hour
Due to Arteriosclerosis	4 years
Due to Chronic Interstitial Nephritis	4 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John S Alexander M. D. or other

Address Glen Burnie Date signed 1/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of cause of death is shown on FILM No G 9 4 APR 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (726)

CERTIFICATE OF DEATH

00140

Reg. Diat. No. 21

1. PLACE OF DEATH:
County A. A. Co.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 810 Spa. Road
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 810 Spa. Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Henry Smith — **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Ida. Smith — 6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Feb. 11 1867

8. AGE: Years	Months	Days	If less than one day
77	11		hrs. min.

9. Birthplace Calvert Co. (Town, county, and state)
10. Usual occupation Labor
11. Industry or business

FATHER
12. Name James Smith
13. Birthplace Md.

MOTHER
14. Maiden name Mary Ellen
15. Birthplace Md.

16. Informant Ida. Smith
Address 810 Spa. Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 19/45 (month) (day) (year)
Cemetery or crematory Hopes Chapel
Location Edgewater, Md.

18. Funeral director J. B. Johnson
Address Annapolis

19. Jan. 18 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1945 at 1145 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8/15 1944 to Jan 16, 1945
and that I last saw h alive on 1945

Immediate cause of death	DURATION
Cardiac Failure	
Due to Mitral stenosis; duration, 5 years. Rheum. F.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Sherlow H. Johnson Md. M. D. or other
Address 35 Northwest Street Date signed 1/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

00141

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County a. a.

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Gambrills

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Laurence William Stockett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

8.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 05 - 1945

8. AGE:

Years	Months	Days	If less than one day
		2	..... hrs. ..... min.

9. Birthplace Annapolis Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name John a Stockett

13. Birthplace Davidsonville, Md

MOTHER

14. Maiden name Ida Adell Tolson

15. Birthplace Annapolis Md.

16. Informant John A. Stockett

Address Gambrills, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan 19/45 (month) (day) (year)

Cemetery or crematory All Hallows

Location Davidsonville Md

18. Funeral director A. L. Hopkins

Address Annapolis Md

19. Jan 19 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17, 1945 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/16/45 1945 to 1/17/45 1945 and that I last saw h.. alive on January 17, 1945

Immediate cause of death	DURATION
Premature Birth (6 mos.)	
Due to	
Due to	
Other conditions (None)	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson M.D. M. D. or other

Address Jan. 17, 1945 Date signed 1/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

00142

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Hour 35 minutes
Hospital, Institution, or street address where death occurred:
U.S.Naval Hospital, Annapolis, Md.
How long in hospital or institution? 1 Hour 35 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Minnesota County: Hennepin
City or town: Minneapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1340 W. Minnehaha
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: BABY BOY SVENDSEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 9, 1945

8. AGE: Years	Months	Days	If less than one day
			1 hrs. 35 min.

9. Birthplace: Annapolis, Anne Arundel Co., Md.
(Town, county, and state)
10. Usual occupation: INFANT
11. Industry or business: -

FATHER
12. Name: Edward Charles Svendsen
13. Birthplace: Minneapolis, Minn.

MOTHER
14. Maiden name: Adelaine Mae Bjorck
15. Birthplace: Minneapolis, Minn.

16. Informant: U.S.Naval Hospital,
Address: Annapolis, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 11th 1945 (month) (day) (year)
Cemetery or crematory: Naval Cemetery
Location: Annapolis Md.
18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. Jan. 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9, 1945, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9, 1945, to January 9, 1945 and that I last saw him alive on January 9, 1945

Immediate cause of death	DURATION
PREMATURE BIRTH	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Clemens, MD
M. D. or other
Address: USN Hospital, Annapolis, Md. Date signed: 1-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

00143

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Brooklyn Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Brooklyn Heights Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 - Davis Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James S. S. Swann Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence A Swann

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 25 - 1865

8. AGE:

Years	Months	Days	If less than one day
80	-	-	..... hrs. ..... min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual occupation: Retired R R Conductor

11. Industry or business: B & O R R Co

FATHER

12. Name: Capt Swann

13. Birthplace: England

MOTHER

14. Maiden name: Mc Powers

15. Birthplace: Balto Md

16. Informant: Mrs. Davis

Address: 204 Davis Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 30-45 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Balto. Md

19. Funeral director: Mattox Undertaking

Address: 3914 S. Hanover St Balto 25 Md

19. January 28 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26th 1945 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1933 to January 26 1945

and that I last saw him alive on January 26 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	about 6 hrs.
Due to: Diabetes	
Due to:	
Other conditions: Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A Lee Boyle M. D. or other

Address: 1340 L. Charles Date signed: 1/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

00145

CERTIFICATE OF DEATH

Reg. Diat. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? sudden death.
Hospital, Institution, or street address where death occurred: 42 Southgate Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 116 South St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Florence Thomas

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 11 1900

8. AGE:

Years	Months	Days	If less than one day
44	5	24	..... hrs. ..... min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Daniel Thomas
13. Birthplace: Md.

MOTHER
14. Maiden name: Rachel Thornley
15. Birthplace: Md.

16. Informant: Dr. Geo. R. Thomas
Address: 53 Calvert St Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/7/45 (month) (day) (year)
Cemetery or crematory: Bruce Hill
Location: Annapolis

18. Funeral director: B. Johnson
Address: Annapolis

19. Jan. 6 1945 (Date rec'd by registrar)
W. T. Munch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 4 1945 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Postmortem Examination and that I last saw ~~him~~ alive on Jany 4 1945

	DURATION
Immediate cause of death: Coronary Occlusion	Hours
Due to: Coronary Sclerosis	Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John M. Coffey Deputy Medical Examiner M. D.
Address: Annapolis, Md. Date signed 1/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134)

00144

CERTIFICATE OF DEATH

Reg. Dist. No. 284

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since January 22, 1934
Hospital, institution, or street address where death occurred:
Cronsville State Hospital
How long in hospital or institution? Since Jan. 22, 1934

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's County
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: California
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS-LOUISE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	M

6.(b) Name of husband or wife: W. Frank Thomas
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1894 ch 2

8. AGE: Years: 50 | Months: Unknown | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Daniel L. Forrest
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Kane
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: January 8/45 (month) (day) (year)
Cemetery or crematory: Holy Trace
Location: Great Mills
18. Funeral director: P.B. Robinson
Address: Leonardtown

19. Jan. 7 19 45 (Date rec'd by registrar) Camalier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5, 19 45, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 22, 19 34, to January 5 19 45
and that I last saw her alive on January 5, 19 45

Immediate cause of death	DURATION
Lung Tuberculosis	2 months
Due to	
Due to	
Other conditions: Dementia Praecox	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert V. Hinderer M. D. or other
Address: Crownsville, Md. Date signed 1/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (179-P)

00146

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, Institution, or street address where death occurred: cor. St. Mary's & Gloucester Sts.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 404 Chester Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Allen Wallace

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	—

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1943

8. AGE: Years	Months	Days	If less than one day
1	5	24	hrs. min.

9. Birthplace 2nd dist. Anne Arundel Cont, Maryland
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name James Wallace
13. Birthplace Annapolis. Md.

MOTHER
14. Maiden name alice Blunt
15. Birthplace Eastport. Md

16. Informant alice Wallace
Address 404 Chester Ave., Eastport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/5/45 (month) (day) (year)
Cemetery or crematory St Mary's Cemetery
Location West St Rd.

18. Funeral director Ethel L. Hyles
Address 45 Northwest St. Annapolis Md.

19. Jan. 5 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 3 1945, at 6.50 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination to

~~and that I last saw h~~ alive on Jany 3 1944

Immediate cause of death	DURATION
Poisoning from	
Due to drinking Kerosene	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 1/2/45
Where did injury occur? Eastport (City or town) A. R. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury Kerosene Injured at work?

23. SIGNATURE John M. Claffy Deputy Md. Examiner M. D. or other
Address Annapolis Md. Date signed 1/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (948)

00147

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 Years

Hospital, institution, or street address where death occurred:
10 Francis Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County a a

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Frances St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James alphonsus Walton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Me	w	married

6.(b) Name of husband or wife Gertrude Fannie Walton

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Feb 16 - 1872

8. AGE: Years	Months	Days	If less than one day
72	11	9	....hrs. ....min.

9. Birthplace Balto md
(Town, county, and state)

10. Usual occupation a a Co Treasurer

11. Industry or business

FATHER 12. Name Wm Henry Plan Walton

13. Birthplace St Marys Co. md

MOTHER 14. Maiden name Juliana Ballard Kent

15. Birthplace a a Co md

16. Informant Gertrude Fannie Walton

Address 10 Frances St Annapolis md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 29/45 (month) (day) (year)

Cemetery or crematory St Marys

Location Annapolis md

18. Funeral director B I Hopkins

Address Annapolis md

19. Jan 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1945 at 9 47 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 21 1945 to Jan 25 1945 and that I last saw h.. alive on Jan 25 1945

Immediate cause of death	DURATION
Coronary Occlusion	4 Days
Due to General Arteriosclerosis	Several Yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J Alvin Purves M. D. or other

Address Annapolis Md Date signed 1/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

00148

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 days
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Annapolis, Maryland
How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 814 Chesapeake Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME: WHITTINGTON, LEWIS B.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 10, 1861

8. AGE: Years	Months	Days	If less than one day
83	5	9	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation:

11. Industry or business: Ret. Chief Master at Arms USN.

FATHER 12. Name: Unknown

13. Birthplace:

MOTHER 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Mrs. Evelyn M. Jacobson
Address: 917 French St. Eastport

17. Burial (Burial, cremation, or removal. Which?) Date thereof: January 22 1945 (month) (day) (year)
Cemetery or crematory: National
Location: Annapolis, Md.

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. Jan. 22 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1945, at 5:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Dec. 1944 to 19 Jan 1945 and that I last saw him alive on 19 Jan 1945

Immediate cause of death	DURATION
Uremia	1 week
Due to: Arteriosclerosis of Kidney	
Due to: Generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: Arteriosclerosis, General

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John B. Leary Lt. (MC) USNR
M. D. or other
Address: U.S.N. Hospital, Annapolis Md. Date signed: 20 Jan. 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

(0114?)

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jones Station

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Same

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sophie Z. Wiseman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph J. Wiseman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 23, 1869.

8. AGE: Years: 75 | Months: 5 | Days: 28 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation: Storekeeper

11. Industry or business: grocery.

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

18. Informant: Joseph A. Wiseman

Address: Arnold. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 24 45 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Balto. Md.

18. Funeral director: B. L. Hopkins

Address: Annapolis. Md.

19. Jan 22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20, 1945 at 9:10 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-13-45, 1945, to 1-20-45, 1945 and that I last saw her alive on 1-19-45, 1945

Immediate cause of death	DURATION
Chronic Myocarditis	1 year
Due to Arteriosclerosis	1 year
Due to	
Other conditions Diabetes Mellitus (Include pregnancy within 3 months of death)	1 year

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harvey M. Moore M.D. M. D. or other

Address: Glen Burnie, Md. Date signed 1-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15